F. Payments to M+C Organizations

1. General Provisions

Part 422 Subpart F sets forth rules that govern payment to M+C organizations, including the methodology used to calculate M+C capitation rates. These rules are based primarily on section 1853 of the Act. (For a complete discussion of these requirements, see the June 26, 1998 interim final rule at 62 FR 35004.)

One of the more significant payment changes in section 1853 of the Act is a gradual transition from rates based on local Medicare costs to "blended" rates based on a 50/50 mix of local and national costs. Under the Adjusted Average Per Capita Cost (AAPCC) payment methodology that applied to section 1876 risk contracts, payment was based on Medicare fee-for-service expenditures in the county in which the enrollee resided. These fee-for-service expenditures were adjusted for demographic factors (that is, age; sex; institutional, welfare, and employment status).

The AAPCC was criticized for its wide range of payment rates among geographic regions: in some cases payment rates varied by over 20 percent between adjacent counties. It was also criticized for its poor risk adjustment capabilities and inappropriate provision of graduate medical education funds to some Medicare risk plans. Moreover, the AAPCC was criticized for

setting erratic annual payment updates, which often made it difficult for contracting health plans to engage in long-term business planning. The BBA introduced a new payment methodology that addressed these and other concerns.

"Greatest of" Payment Rate: Since January 1, 1998 (when the M+C payment methodology under section 1853 was made applicable to section 1876 risk contractors pursuant to section 1876(k)(3) of the Act), the Medicare capitation rate for a given county has been the greatest of: (1) the above-referenced blended capitation rate; (2) a “minimum amount” rate established by statute; or (3) a minimum percentage increase. These county rates are then adjusted by demographic factors (and after 2000, by risk adjustment factors) to determine the actual payment amount.

**!** The blended capitation rate is a blend of the area-specific (local) rate and the national rate, with the latter adjusted for input prices. The blended capitation rate is then adjusted by a budget neutrality factor designed to ensure that payment is not higher than it would be under purely local rates.

**!** The minimum amount rate was $367 per month per enrollee in 1998 for all areas in the 50 States and the District of Columbia. Outside the 50 States and the District of Columbia, the rate was limited to 150 percent of the 1997 AAPCC for the area in question, if this amount was lower than $367. The minimum amount

rate is adjusted each year using the update factors described in §422.254(b).

**!** The minimum percentage increase is 2 percent. The minimum percentage increase rate for 1998 was 102 percent of the 1997 AAPCC. Thereafter, it is 102 percent of the prior year's capitation rate.

With the exception of payments under M+C MSA plans, we pay M+C organizations monthly payments for each enrollee in an M+C plan they offer 1/12th of the annual M+C capitation rate for the payment area described in §422.250(c). Except for ESRD enrollees, these payments are adjusted for such demographic risk factors as an individual's age, disability status, sex, institutional status, and other factors determined to be appropriate to ensure actuarial equivalence. Since January 1, 2000, these rates also have been adjusted for health status as provided in §422.256(c). For 2000, only 10 percent of the capitation payment will be risk adjusted, with the other 90 percent determined based on the 1999 methodology.

Comment: Several commenters contended that section 1853(c) of the Act set forth artificial and arbitrary limits on capitation rate increases. Because the budget neutrality adjustment applies only to the “blended rate,” and the final rate is based on the greatest of the three rates specified, it was not possible to achieve budget neutrality in 1998 or 1999. Once the

blended rate was lowered below at least one of the other two rates in each county, no further savings could be achieved through a budget neutrality adjustment. As a result of the adjustments made in an attempt to achieve budget neutrality, however, capitation rates in 1998 and 1999 were all based either on the minimum percentage increase of 2 percent from the prior year, or the new minimum payment rate. The commenters argued that the effect of this would be that M+C organizations would withdraw from Medicare, either entirely or in low payment areas. These commenters suggested that we propose legislative changes to section 1853 of the Act in order to change the formula used to calculate the county payment rates.

Response: The commenter's suggestions concerning changes in legislation are outside the scope of this rulemaking. In this rulemaking, we are charged with implementing the BBA as enacted (and in this final rule, as revised by the BBRA).

However, passage of the BBRA may alleviate some concerns of the commenters. The BBRA requires several modifications to the payment calculations set forth in the BBA, including: lowering the reduction of the national per capita growth percentage defined in §422.254(b), offering bonus payments to eligible M+C organizations as described in §422.250(g), and revising our original schedule for transitioning to risk-adjusted payments to providing for an even more gradual introduction of risk

adjustment. (See Section I.C for a full discussion of the BBRA provisions.)

Comment: One commenter wanted to know if adjusted excess amounts (determined through the Adjusted Community Rate process identified in §422.312) affect the computation of the county payment rates if these amounts are placed in a stabilization fund, described in §422.252.

Response: Amounts deposited in a stabilization fund reduce the payment to the M+C organization for the year in which the funds are deposited (the organization gives up that amount to use it for benefits in a future year), but do not affect the county payment rates.

Comment: Some commenters argued that funding for the ESRD network (§422.250(a)2)(B)) should not be taken from capitation payments to M+C organizations.

Response: Section 422.250(a)(2)(B) implements section 1853(a)(1)(B) of the Act, which specifically requires this reduction in payment rates for enrollees with ESRD. We have, however, changed the wording of our regulations to ensure that the amount taken from the capitation payments remains consistent with the amount required under section 1881(b)(7) of the Act. This does not change our current policy in any way; it merely allows that, if the amount mandated by changes in section 1881 of the Act changes for any reason, our regulations at

§422.250(a)(2)(B) will remain consistent with such a change.

Comment: One commenter requested clarification on the application of the budget neutrality adjustment contained in §422.250(e)(3).

Response: Section 422.250(e)(1) allows a State's chief executive to request a geographic adjustment of the State's payment areas for the following calendar year. The chief executive may elect to change the area in which a uniform rate is paid from a county to one of the three alternative payment areas identified in §422.250(e)(1). Specifically, the governor may choose to have--(1) a single Statewide M+C payment area, (2) a single non-metropolitan payment area, with a separate payment area including metropolitan areas defined in one of two ways, or (3) consolidation of non-contiguous counties. Section 422.250(e)(3) requires us to make a budget neutrality adjustment to all payment areas within that state regardless of which payment area designation is selected by the chief executive. The budget neutrality adjustment is designed to limit the aggregate Medicare payment for Medicare enrollees residing in that state to what would have been paid absent any geographic adjustment.

Comment: One commenter proposed a statutory change that would permit a budget neutrality adjustment to be made to the final capitation rate, not just the "blended rate," as currently provided. Such a change could result in lower payment rates.

Response: The full impact of the BBA and the subsequent revisions included in the BBRA are not yet known; thus, it may be too soon to give Congress recommendations that would have a major effect on our payment to managed care organizations. Therefore, we are not pursuing such a statutory change at this time.

Comment: One commenter suggested that we provide for increased payments to an M+C organization for Part B services provided by contract with federally qualified health centers, and require the increased payment be passed on these centers.

Response: The statute does not authorize us to pay certain M+C organizations differently than others, other than the special rules that apply to determining payments made to an M+C organization offering an M+C MSA plan. Payment for services furnished by a contracting federally qualified health center is limited to the amount negotiated by the two entities.

Comment: One commenter suggested that payment rates should be structured on a regional basis instead of a county by county basis.

Response: Section 1853(d) of the Act defines what is considered an M+C payment area. For Medicare enrollees without ESRD, the payment area is a county. For Medicare enrollees with ESRD, the payment area is a State. The only exception to these rules would be a State that has exercised its right under section 1853(d)(3) of the Act to request an alternative payment area in

accordance with §422.252(e).

Comment: A commenter believes that it is important that M+C organizations have the opportunity to validate our calculations and methodology in calculating payment rates. The commenter accordingly suggested that we cooperate with interested parties by releasing sufficient data to allow those parties to validate our calculations.

Response: We agree. We have complied, and will continue to comply, with all reasonable requests for all relevant and releasable data. M+C organizations must keep in mind that we use a significant amount of confidential data that cannot be released to the public.

2. Risk adjustment and encounter data (§§422.256 through 422.258)

Section 1853(a)(3) of the Act required implementation of risk adjustment for payment periods beginning on or after January 1, 2000. In the June 26, 1998 rule, we provided for such risk adjustment in §422.256(d). We also provided that, in the period prior to the implementation of risk adjustment, we would continue to apply the demographic adjustments used under the old AAPCC methodology.

On September 8, 1998, we published a **Federal Register** notice describing our preliminary risk adjustment methodology and requesting public comments (53 FR 173, pp. 47506 et seq.). On

January 15, 1999, we published an advance notice, as provided under §422.258(b) of the regulations, describing the risk adjustment methodology that we implemented for 2000. This advance notice included a detailed description of the new risk adjustment methodology that is in effect in 2000, and information on how risk adjustment will be implemented, including an explanation of the transition method that would be employed. It also responded to comments received in response to the September 8, 1998 **Federal Register** notice. Briefly, the approach we used to meet the year 2000 mandate for risk adjusted payments was:

(1) Based on inpatient data;

(2) Applied individual enrollee risk scores in determining fully capitated payments;

(3) Utilized a prospective PIP-DCG risk adjuster to estimate relative beneficiary risk scores;

(4) Applied separate demographic-only factors to new Medicare enrollees for whom no diagnostic history is available;

(5) Applied a rescaling factor to address inconsistencies between demographic factors in the rate book and the new risk adjusters;

(6) Used 6-month-old diagnostic data to assign PIP-DCG categories (the “time shift” model, as opposed to using

the most recent data and making retroactive adjustments of payment rates part way through the year);

(7) Allowed for a reconciliation after the payment year to account for late submissions of encounter data;

(8) Phased-in the effects of risk adjustment, beginning with a blend of 90 percent of the demographically-adjusted payment rate, and 10 percent of the risk-adjusted payment rate in the first year (CY 2000); and

(9) Implemented processes to collect encounter data on additional services, and move to a full risk adjustment model as soon as is feasible.

On March 1, 1999, we published the annual Announcement of Calendar Year (CY) 2000 Medicare+Choice Payment Rates, as provided under §422.266(a) of the regulations. In this announcement, we informed Medicare+Choice organizations of the county rates and factors that were employed for payment in calendar year 2000, including the rescaling factors for use with the risk adjusted portion of payment, and tables of risk and demographic adjustment factors. We also responded to questions and comments on the January 15 notice. (These notices are available on the HCFA Web site, at http://www.hcfa.gov/stats/hmorates/aapccpg.htm.)

Section 1853(a)(3)(B) of the Act provided for the collection from M+C organizations, of encounter data needed to implement the

risk adjustment methodology. The BBA required the collection of inpatient hospital data for discharges beginning on or after July 1, 1997, and allowed the collection of other data for periods beginning on or after July 1, 1998. We were prohibited from requiring the actual submission of data before January 1, 1998. This data submission requirement appeared in section 1853(a)(3) of the Act, which was titled "Establishment of Risk Adjustment Factors." (See §422.256(d).)

Requirements concerning collection of encounter data apply to M+C organizations with respect to all M+C plans, including private fee-for-service plans. Instructions for the collection of hospital encounter data were sent to M+C organizations in December 1997 (OPL 97.064) and May 1998 (OPL 98.71). Hospital discharges for the period July 1, 1997 through June 30, 1998 have been collected and used for estimating the impact of risk adjustment at the contract level and in the aggregate. We announced in the January 15, 1999 notice of methodological changes that comprehensive risk adjustment would be implemented for payments beginning on January 1, 2004. We will soon be providing M+C organizations with guidance concerning requirements for submission of outpatient, physician, and other non-inpatient encounter data.

There are two different ways encounter data are used for risk-adjustment purposes. To calculate payment rates, encounter

data are necessary to tie payment to expected patient resource use using diagnosis codes. (The initial risk-adjusted payment will be based on inpatient hospital encounter data. However, we are developing a more comprehensive risk-adjustment methodology that uses diagnosis data from physician services and hospital outpatient department encounters.) Encounter data are also necessary to "recalibrate" any risk-adjusted payment model. Recalibration adjusts payment models for changes in resource requirements that derive from such factors as technological change and improved coding.

While these are the primary purposes collecting the encounter data, we discussed other possible uses of these data in the June 1998 interim final rule. These other uses include identification of quality improvement targets and monitoring the care received by M+C enrollees through targeted special studies (such as an examination of post-acute care utilization patterns). Encounter data will also be useful for program integrity functions, both by providing additional utilization norms for original Medicare billing and by providing additional information regarding M+C organizations' behavior.

As noted above, the notices of January 15, 1999, and March 1, 1999, contained detailed discussions of the risk adjustment methodology and responses to comments. Similar notices, reflecting BBRA changes, and our methodology and rates for 2001,

were published in January and March of 2000. Here we respond formally to comments submitted on the June 26, 1998 rule.

Comment: A number of commenters recommended that we not adopt a risk adjustment system based solely on hospital encounter data. As a matter of public policy, the commenters objected that basing the initial risk adjustment methodology solely on inpatient data would create inappropriate incentives to hospitalize patients, skew payments toward plans with higher hospitalizations, and penalize plans that have appropriately reduced inpatient services by focusing on outpatient care. Other commenters requested a phase-in of the methodology to minimize the disruption on M+C organizations, and allow time to assess the impact of the new methodology.

Response: We do not believe it would be desirable to delay implementation of risk adjustment until data other than inpatient data are available. We have analyzed the PIP-DCG system sufficiently to be confident that it represents an improvement over the current system of demographic-only adjustment, that it provides an appropriate interim step toward a comprehensive risk adjustment model, and that it provides appropriate levels of payment for different classes of beneficiaries. We believe that the blend transition methodology should relieve concerns about disruption of payments, especially since the initial blend percentage for the risk-adjusted portion is 10 percent.

Even if we believed that delaying risk adjustment were desirable, we do not have the authority to do so. The Balanced Budget Act specifically required "implementation of a risk adjustment methodology...no later than January 1, 2000." In order to meet that deadline, we were constrained to employ a model based on hospital encounter data alone in the interim until the data to implement a comprehensive risk adjustment methodology can be provided by all plans and processed by us. The Medicare+Choice legislation (section 1853(a)(3)(B) of the Act) provided for the collection of non-inpatient data for periods beginning on or after July 1, 1998, a full year later than the date for which inpatient data would be collected. This provision envisioned that a hospital-only system would be implemented initially, both because it seemed more feasible for M+C organizations to produce inpatient data only in the short term, and because the effect of a hospital-only system on payments would be smaller than a system based on comprehensive encounter data. (The Medicare+Choice regulations further provided that we would collect physician, outpatient hospital, SNF, or HHA data no earlier than October 1, 1999. See §422.257(b)(2)(i).) However, the statute grants us broad authority to develop a risk adjustment methodology, and does not prohibit us from including a transition or "phase-in" period as a component of the methodology we develop.

We therefore included a transition period as a component of our risk adjustment methodology, initially using a blend of payment amounts under the current demographic system and the PIP-DCG risk adjustment methodology. Under a blend, payment amounts for each enrollee would be separately determined using the demographic and risk methodologies (that is, taking the separate demographic and risk rate books and applying the demographic and risk adjustments, respectively). Those payment amounts would then be blended according to the percentages for the transition year.

In order to provide adequate safeguards against abrupt changes in payment, our transition mechanism initially provided for a low blend percentage of the risk-adjusted payment rate. Specifically, first year blend percentages will be 90 percent of the demographically adjusted rates, and 10 percent of the risk-adjusted payment rate. We are also contemplating a five-year transition, which would culminate in full implementation of comprehensive risk adjustment, using all encounter data, in the fifth year. Our initial transition schedule, announced in the January 5, 1999, Advance Notice of Methodological Changes for the CY 2000 Medicare+Choice Payment Rates was:

| | Demographic method | Risk method |
|---|---|---|
| CY 2000 | 90 percent | 10 percent |
| CY 2001 | 70 percent | 30 percent |

| | | |
|---|---|---|
| CY 2002 | 45 percent | 55 percent |
| CY 2003 | 20 percent | 80 percent |
| CY 2004 | 100 percent comprehensive risk adjustment (using encounter data from multiple sites of care) | |

Subsequently, passage of Section 511(a) of the BBRA has revised the original transition schedule, providing for an even more gradual introduction of risk adjustment. Specifically, the legislation provides that the blend percentages will be:

| | Demographic method | Risk method |
|---|---|---|
| CY 2000 | 90 percent | 10 percent |
| CY 2001 | 90 percent | 10 percent |
| CY 2002 | at least 80 percent | no more than 20 percent |

In order to implement comprehensive risk adjustment in CY 2004, we will soon be providing M+C organizations with guidance concerning requirements for submission of outpatient, physician, and other non-inpatient encounter data.

Comment: Some commenters emphasized that implementation of risk adjustment could inject uncertainty and reduce the predictability of payments to M+C plans.

Response: Our most recent estimate, based on the 285 organizations that were active in September, 1998, and that did not terminate their contracts with Medicare in 1999, (including 10 organizations that merged into other active M+C organizations as of January 1, 1999), was that aggregate payments would

decrease 0.6 percent, taking into account the blend percentages in effect for 2000, (90 percent demographic adjusted amount, 10 percent risk adjusted amount). While the impact on specific organizations will vary, our analysis suggests that, except for highly unusual circumstances (for example, a high proportion of working aged enrollees), the maximum decrease in payment to any organization from risk adjustment alone will be less than 2 percent. The analysis did not suggest that smaller organizations, or any other specific category, would experience a disproportionate impact. We will, however, continue to monitor the impacts on organizations throughout the transition period. We believe that our transition mechanism should alleviate concerns about large and abrupt changes in payment.

Comment: One commenter expressed concern about the effect on people with Alzheimer's disease of a risk adjustment methodology based solely on hospital encounter data. Because Alzheimer's and dementia are often not included in the recorded diagnoses of hospitalized beneficiaries, hospital data alone cannot support accurate conclusions about the cost of hospital care for these beneficiaries. Several other commenters expressed similar concerns about the implications of the initial risk adjustment methodology for beneficiaries with other chronic conditions.

Response: Our validation tests on the PIP-DCG model

actually show that this model offers a substantial improvement over the system of demographic-only adjustments that has been previously in use. One measure of a model's accuracy is its ability to predict mean expenditures for groups correctly. Health Economics Research (HER), which served as a contractor to HCFA in developing the PIP-DCG model, measured the predictive ratios, (that is, the ratio of mean predicted expenditures to mean actual expenditures), for groups of Medicare beneficiaries that are of policy or technical interest. Among the groups used in this validation analysis were chronic condition groups, defined by ambulatory as well as inpatient diagnoses. HER found that, while the PIP-DCG model underpredicted for many chronic disease groups, this model performed better than the demographic model. For example, the predictive performance for persons with dementia (which includes individuals diagnosed with Alzheimer's) increased from 0.91 under the demographic system to 1.07 under the PIP-DCG model. Further detail on the validation analyses can be found in our "Report to Congress: Proposed Method of Incorporating Health Status Risk Adjusters into Medicare+Choice Payments," and in the HER report "Principal Inpatient Diagnostic Cost Models for Medicare Risk Adjustment," which is appended to it. The reports can be found on our Web site (http://www.hcfa.gov/ord/rpt2cong.pdf).

Comment: One commenter objected that the risk adjustment

system does not account for secondary diagnoses. A patient with two acute diagnoses could be more ill and more costly than a patient with the same primary diagnosis, but a less severe secondary diagnosis. Another commenter supported the development of an initial risk adjustment methodology based on inpatient data alone, since inpatient costs represent the largest expense item of health plans. But this commenter recommended that such a methodology should account for both primary and secondary diagnoses, since secondary diagnoses are necessary to account for the higher costs of beneficiaries with multiple health problems and chronic conditions that are more expensive to treat.

Response: The analysis conducted in the early stages of developing an inpatient-based risk adjustment model included consideration of incorporating secondary diagnoses. The analysis concluded that secondary diagnoses did not contribute significantly to predictive accuracy in the context of an inpatient model. As noted above, the inpatient hospital model represents a significant improvement in predictive accuracy over the demographic adjustments that have been in use. However, it is only an interim step toward a comprehensive risk adjustment system. We anticipate that the comprehensive risk adjustment model under development will base risk scores on multiple diagnoses from disparate sites of care.

Comment: One commenter recommended that we develop the

capability to use diagnosis data from all sites of care as quickly as possible in the risk adjustment system. Other commenters expressed concern about the costs and burdens of collecting the physician, outpatient hospital, skilled nursing facility, and home health agency encounter data that will be necessary for the implementation of comprehensive encounter data in 2004. Several commenters objected that the time frame contemplated for the submission of these data is too short to allow M+C organizations to procure and install the required systems. One commenter urged that, in preparing for submission of encounter data from physician offices, mechanisms should be established for the transition from paper claims to electronic bills for those practices that "have not entered the electronic age."

Response: The PIP-DCG model represents a substantial improvement over the current system. Because it identifies a subset of seriously ill beneficiaries for increased payment and because the effect of a hospital-only system on payments is smaller than a system based on comprehensive encounter data, the PIP-DCG model is an appropriate interim step toward comprehensive risk adjustment. A comprehensive model is nevertheless preferable, and we plan to move toward implementing such a model as expeditiously as possible. However, implementation of the comprehensive risk adjustment model is not operationally feasible

for 3 to 4 years, because of data constraints on both plans and on us. The transition plan announced in the January 15, 1999 notice therefore provides for implementation of comprehensive risk adjustment in 2004, without ever reaching full payment under the PIP-DCG system. In the interim, the PIP-DCG model offers a substantial improvement over the current system.

In providing for payment under a comprehensive risk adjustment system in 2004, we have taken into account the costs and burdens necessary for organizations to develop the capacity for collecting and submitting physician, outpatient hospital, skilled nursing facility, and home health agency encounter data. This is the most ambitious schedule that we believe we can adopt consistent with allowing sufficient time for organizations and the agency to prepare.

Comment: A number of commenters objected that the collection of encounter data is burdensome and expensive. Some commenters asserted that this requirement may deter new managed care contractors, especially smaller organizations, from participating in the M+C program. Several commenters observed that not all the data required for submission of encounter data are necessary for computing risk adjustment. Another commenter urged us to monitor the trade-off between risk adjustment accuracy and risk adjustment data-collection requirements, and seek opportunities to streamline the burdens of encounter data

collection. One commenter recommended that we explore alternatives to collection of all encounter data, such as survey-based approaches.

Response: We have made every effort to minimize the burden of collecting encounter data, and to assist M+C organizations with problems that have arisen in collecting and processing these data. In the initial stages of collecting encounter data, we are permitting organizations to use an abbreviated version of the standard UB-92 form employed in hospital billing. Data elements in the abbreviated UB-92 form have been restricted to those items necessary to calculating risk scores and pricing the discharge, as well as some document identification items that are normally generated automatically in electronic processing. (As we discuss below, pricing of discharges is necessary to allow recalibration of the model.) Use of the abbreviated UB-92 form will be allowed for discharges at least through June 30, 2001.

The legislation mandating risk adjustment also provides for the collection of inpatient and other encounter data. The legislation therefore contemplates a risk adjustment system based on encounter data rather than surveys. We believe that the greater accuracy of a system based on full submission of encounter data justifies the additional burdens that this requirement entails.

A range of problems in the submission of encounter data have

arisen. These problems have included: not following the required UB-92 format, difficulties in accurately tracking counts of discharges, failure to arrange hospital submission of encounter data, difficulties in understanding Fiscal Intermediary reports, and HCFA/FI and FSS processing problems. Plans themselves may have problematic data processing systems in-house. We have worked with Medicare+Choice organizations, managed care associations, and other parties to address many specific issues that have arisen concerning data transmission and processing, and we will continue to do so. We have taken a number of specific steps to facilitate and improve the encounter data submission process. These activities have included the following:

**!** Encounter Data Reconciliation Analyses--We have shared with M+C organizations analyses of their individual M+C plan level data. The data have been successfully posted at our offices. We have further conducted analyses upon request at the provider level and by the different methods of submission to help explain discrepancies. We are in the process of sharing these analyses with the plans. The detailed provider level analyses are requiring additional time to conduct, and the results of these analyses will be shared with plans over the coming weeks.

**!** Onsite Consultations--Our contractor conducted a series of onsite consultation visits to 20 M+C organizations in order to learn more about the process of data submission. The majority of

the 20 organizations selected for the visits were those that experienced problems with encounter data submission. The information gained during these visits will be used to assist plans to identify and resolve problems.

**!** HCFA Data System Fixes--Processing problems have been identified that relate to beneficiaries who change from one M+C plan to another. The estimated number of affected encounters from all plans is less than 3,000. These problems will be fixed over the next 2 months, and they are not expected to impact the March 1 rate estimates, which, in any case, will not be used to make direct enrollee payments.

**!** Communication with the FIs--We have shared data problems raised by M+C organizations with the FIs. Furthermore, discussions between us, FI's, and plans have been encouraged in order to address problems.

Comment: Several commenters objected that we should not place the burden of collecting encounter data and assuring their accuracy solely on M+C organizations, but rather on the providers submitting the data to the organizations. Some of these commenters suggested imposition of a requirement on providers that they cooperate with M+C organizations in collecting encounter data.

Response: We did not include requirements on providers in the interim final rule because we traditionally have tried to

minimize the adoption of measures that would insert our requirements into the contractual relationships between managed care organizations and providers. We therefore suggested to M+C organizations that they modify their contracts with hospitals to ensure that managed care discharges are identified, and the appropriate records are provided to the organization by the hospital. We also have taken every opportunity to inform hospitals and hospital associations of the encounter data requirements and the importance of collecting complete and accurate encounter data to assure correct payment. Collection of encounter data for the "start up" year of July 1997 through June 1998, which was the basis for estimating the impacts of risk adjustment, was quite successful, and we have every reason to believe that collection of data for the next year, which will be used to determine actual risk adjustments in 2000, will go at least as well.

However, M+C organizations have informed us that some providers are either failing to submit encounter data at all, or submitting data that do not conform to quality standards for submission to our systems (for example, that the coding often fails to meet standards required to pass the coding edits). To the extent usable data are not submitted, M+C organizations are denied the benefit of any risk adjustment that might be justified based on the costs in question. We are therefore proposing to

make several changes to the rules that are designed to give M+C organizations greater leverage in obtaining adequate cooperation from providers to submit complete and accurate data.

First, we will make explicit in §422.257 that M+C organizations are required to obtain from providers, suppliers, physicians, or other practitioners information sufficient to submit the required encounter data. (Currently the regulation states that M+C organizations must submit encounter data, but leaves the requirement of obtaining the necessary information from providers and others to inference.)

Second, we will specifically state in the rules that M+C organizations may include a requirement for submission of complete and accurate encounter data, conforming to the format used under original Medicare, in their contracts with providers, suppliers, physicians, and other practitioners. Contracts with providers and others may impose financial penalties, including withholding payment, for failure to submit complete and accurate data conforming to all requirements for submission. We have revised §422.257 of the regulations to reflect these two changes.

Third, as discussed below in section K, we have modified the definition of “clean claim” in §422.500 to specify that a claim must include information necessary for purposes of encounter data requirements, and must conform to the requirements for a clean claim under original Medicare. This will exempt claims that do

not, for example, meet accurate coding requirements from the application of the “prompt payment” standard that applies to claims submitted by non-contracting providers. This standard requires that “clean claims” submitted by non-contracting providers be paid within 30 days, or interest will be owed. M+C organizations will therefore be able to withhold payment in cases in which non-contracting providers submit claims with inadequate coding or other deficiencies that make the claims impossible to use for encounter data purposes.

Fourth, we are providing a reconciliation process which will give M+C organizations additional time to submit encounter data before final payment determinations are made. M+C organizations have approximately 3 months after the end of a data collection year to submit the encounter data that will be used to develop beneficiary risk scores to their fiscal intermediary. For example, M+C organizations must submit encounter data for the period July 1, 1998 through June 30, 1999 to their fiscal intermediary by September 17, 1999. If organizations submit encounters after this date, they will not be incorporated into payments for CY 2000. However, in response to concerns expressed by M+C organizations over this short time frame, we expect to institute a reconciliation process that will take into account late data submissions. M+C organizations should attempt to have all data in by the annual deadline of September 10. However, if

organizations receive UB-92s from hospitals after this date, they may submit the encounter to their fiscal intermediary and the data will be processed. M+C organizations should note that the deadline for submission of all data from a payment year will be June 30 of the payment year for the period ending the previous June 30 (for example, the final deadline for the period of July 1, 1998 to June 30, 1999, which is used for payment in 2000, will be June 30, 2000). After that date, the fiscal intermediary will no longer accept these data. After the payment year is completed, we will recalculate risk factors for individuals who have late encounters submitted. Then, we will determine any payment adjustments that are required. This reconciliation will be undertaken after the close of a payment year and will be a one-time only reconciliation for each payment year. We are adding §422.256(g) to provide for this reconciliation process.

Comment: Some commenters expressed doubts about the completeness and accuracy of the encounter data submitted during the "start up year," which was used to develop estimates of the impact of risk adjustment. Some expressed concern that systems problems have impeded the posting of complete and accurate data. Several commenters expressed doubts that sufficiently complete and accurate encounter data could be available in time to begin risk-adjusted payment on January 1, 2000.

Response: Hospital encounter data were collected from

managed care organizations for discharges between July 1, 1997 and June 30, 1998. Approximately 1.5 million encounters were submitted to us for over 5.7 million beneficiaries. The volume of data received is sufficient to generate an estimate of the impact of risk adjustment, and to conduct other analysis in order to prepare for implementation of risk adjustment. Based on this experience, we are confident that sufficient data will be generated to calculate beneficiary risk scores and other information necessary for implementation of the PIP-DCG model.

Comment: One commenter requested clarification of the statement in the preamble that encounter data may be used for purposes other than calculating risk adjustments.

Response: We commonly use data collected in the course of calculating payments for other purposes. These purposes include monitoring program integrity, studying utilization patterns and quality of care, and a variety of research purposes. Our use of data is always governed by consideration of privacy concerns and confidentiality of business operations.

Comment: Several commenters asked for further information concerning how we intend to recalibrate risk-adjusted payments to account for upcoding. Another commenter questioned whether use of the full UB-92 is necessary for this recalibration, and suggested that we consider other approaches.

Response: As we discussed above, recalibration is necessary

to adjust the payment models for changes in resource requirements that derive from such factors as technological change and improved coding. Upcoding may occur if plans improve coding of beneficiary diagnoses and, as a result, the average use of resources for enrollees in a particular category may be less than when the relative payment rates were determined. When this happens, the average actual expenditures per enrollee for these diagnoses may be less than the average expenditures used to assign the original payment weights. The result is overpayment for some diagnoses in the risk adjustment model. On the other hand, technological changes, which often result in more intensive use of resources for certain diagnoses, can lead to underpayment for certain diagnoses unless the model is recalibrated. Recalibration is a standard feature of well-established payment systems, such as the hospital prospective payment system. We have not yet developed a specific timetable for recalibrating the PIP-DCG model. We will not recalibrate the model until we have sufficient data from Medicare+Choice organizations to incorporate managed care practice patterns into the recalibration.

Comment: Several commenters expressed concern about the attestations required of M+C organizations, with respect to the accuracy and completeness of encounter data. One of these commenters expressed the view that the requirement for an attestation that submitted encounter data are “accurate,

complete, and truthful" is designed more as a legal trap for those that might innocently submit incomplete or inaccurate data, than as good public policy. Another commenter recommended that the attestation allow for honest mistakes and unavoidable margins of error.

Response: Attestation of encounter data has been a contentious issue. Attestation of encounter data is essential for guaranteeing the accuracy and completeness of data submitted for payment purposes, and to allow us to pursue penalties under the False Claim Act, where it can be proven that a plan knowingly submitted false data. However, in response to concerns from M+C organizations, we have restricted the attestation requirement to confirmation of the completeness of the data and the accuracy of coding. Since this is information that M+C organizations are, or should be, in the position to know, the attestation requirement is thus in no way a legal trap.

Comment: One commenter recommended that we develop mechanisms, with the assistance of consumer representatives, to make encounter data available to Medicare beneficiaries and their representatives.

Response: The commenter did not identify the "beneficiary representatives" to whom encounter data would be made available, nor the purposes for which the data would be used. We would consider specific requests for data in the light of privacy and

other considerations which normally govern the use of data gathered for official purposes in the program.

Comment: Several commenters expressed concern about the short time frame for submission of Adjusted Community Rate proposals after the release of county rates, rescaling factors, and risk adjustment impact estimates on March 1. The commenter urged disclosure of key information such as the rescaling factors earlier in order to give plans the opportunity to base their rate and benefit submissions on more complete financial information.

Response: Section 516 of the BBRA extended the ACR deadline to July 1, and applied that extension retroactively to 1999. Therefore, we have changed our regulations at §422.306(a)(1) to reflect this statutory change, which has addressed the commenter's concerns.

3. Special Rules for Hospice Care (§422.266)

Comment: One commenter requested clarification on reporting institutionalized members who have elected hospice care, and how the M+C organizations will determine whether a new member is in hospice care.

Response: Medicare enrollees who have elected hospice care should not be reported as institutionalized. Medicare beneficiaries that have elected hospice, and subsequently elect an M+C plan will be identified by our system.

Comment: One commenter requested clarification of the M+C

organization's responsibility in arranging for the provision of hospice care for those enrollees who have elected hospice care.

Response: Section 422.266 requires the M+C organization to inform each Medicare enrollee eligible to elect hospice care about the availability of hospice care in the area or outside the area, if it is common practice to refer patients accordingly. An M+C organization is not required to arrange for hospice services when the hospice election has been made.

Comment: One commenter requested further clarification on our payment for a Medicare enrollee when the enrollee elects hospice.

Response: Our monthly capitation is reduced to the adjusted excess amount developed in the ACR. The amount of the reduction is the ACR value (less the actuarial value of Medicare's deductibles and co-insurance) for Medicare-covered items and services. For Medicare-covered items and services, the M+C organization or provider furnishing the service would bill us using Medicare's normal billing rules under original Medicare. Also, hospice services are billed under original Medicare rules.